DEPARTMENT OF HEALTH SERVICES

714/744 P STREET P.O. BOX 942732 SACRAMENTO, CA 94234-7320 (916) 322-1584



CMSP Letter: 97-6

Date Issued: DEC 0 5 1997

TO:

ALL COUNTY MEDICAL SERVICES PROGRAM (CMSP) WELFARE

DIRECTORS

SUBJECT:

VERIFICATION OF FISCAL YEAR (FY) 1996-97 CMSP ELIGIBILITY

EXPENDITURES

The purpose of this letter is to request verification of County Administrative Costs associated with the CMSP. Enclosed is a worksheet listing CMSP eligibility expenditures for FY 1996-97.

Since these data are used to determine necessary recoupments and reallocations of these funds, it is necessary that you review the accuracy of these data for your county. If your county has submitted supplemental (adjusted) Administrative Cost Claims which impact the CMSP, it is likely that they are not reflected in these data. Such claims will be considered if you complete and return the enclosed "CMSP Amended Eligibility Expenditures Report" by December 31, 1997. Please note that supplemental claims filed after December 31, 1997 cannot be considered since that date is the cutoff for the FY 1996-97. This form must also be used to provide "corrected" information from the original Administrative Cost Claim submitted for each quarter.

If you find the information is correct, there is no need to take any further action. If additional or corrected information is identified, please send completed reports to:

Office of County Health Services
California Department of Health Services
Attention: Mr. Gary Varner
1800 3rd Street, Room 100
P.O. Box 942732
Sacramento, CA 94234-7320

If you have any questions regrading this report, please contact Mr. Gary Varner of my staff by phone at (916) 322-1613 or facsimile at (916) 323-3350.

Linda McFarland, Chief

County Medical Services Program Unit

Enclosures

cc: Mr. Gary Varner

Office of County Health Services

California Department of Health Services

1800 3rd Street, Room 100

P.O. Box 942732

Sacramento, CA 94234-7320

COUNTY MEDICAL SERVICES PROGRAM AMENDED ELIGIBILITY EXPENDITURE REPORT FOR THE STATE FISCAL YEAR 1996-97

QUARTER:		
AMOUNT FROM DHS WORKSHEET		\$
CORRECTED AMOUNT		\$
SUPPLEMENTAL CLAIM DATE:		
SUPPLEMENTAL CLAIM AMOUNT		\$
REVISED TOTAL FOR THIS QUARTER		\$
QUARTER:	_	
AMOUNT FROM DHS WORKSHEET		\$
CORRECTED AMOUNT		\$
SUPPLEMENTAL CLAIM DATE:		
SUPPLEMENTAL CLAIM AMOUNT		\$
REVISED TOTAL FOR THIS QUARTER		\$
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(PRINTED NAME/TITLE)	(SIGNATURE)	(DATE)

Revised: 12/97

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